STATE OF MICHIGAN

DEPARTMENT OF CONSUMER & INDUSTRY SERVICES

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 85592-001**

v

Care Choices HMO
Respondent
_____/

Issued and entered
this 14th day of January 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On October 5, 2007, XXXXX filed, on behalf of her husband XXXXX (Petitioner), a request for an expedited external review with the Commissioner of the Office of Financial and Insurance Services under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*. However, this case involves an adverse determination issued after the health care in question had been completed. Section 13(11) of the PRIRA, MCL 550.1913(11), prohibits expedited external reviews of retrospective final adverse determinations. The Commissioner accepted the request for external review on a non-expedited basis on October 12, 2007.

The case required analysis by a medical professional. Therefore, the Commissioner assigned the matter to an independent review organization (IRO) as required by section 11(6) of the PRIRA (MCL 550.1911[6]). The IRO submitted its recommendation to the Office of Financial and Insurance Services on October 29, 2007.

II
FACTUAL BACKGROUND

The Petitioner is XX years old and has a history of bipolar disorder. Following an in-patient stay, Petitioner was admitted to a "partial hospitalization" program at XXXXX Hospital in XXXXX, XXXXX from January 2 through January 19, XXXX. The program provides for treatment at the hospital without either an actual admission or overnight care as an in-patient. His health maintenance organization, Care Choices, denied coverage. [1]

The Petitioner exhausted the Care Choices internal grievance process and received its final adverse determination letter dated September 25, 2007.

The Commissioner notes that the Petitioner is past the age of 65 when most people are eligible to receive Medicare benefits. The Petitioner did not raise Medicare coverage in his appeal, nor did the Respondent in its response. While it is possible that Medicare coverage may provide additional benefits for the care the Petitioner received, Medicare coverage is not relevant to the issue presented in this PRIRA review.

III
ISSUE

Did Care Choices properly deny the Petitioner coverage for the XXXXX program?

IV
ANALYSIS

Petitioner's Argument

The Petitioner's wife says that, at the time of his admission, her husband had M-CARE health benefits, but on January 1, 2007 his coverage changed to Care Choices. Care Choices denied coverage for the partial hospitalization program. The Petitioner believes the hospital should have helped him understand his coverage and that the partial hospitalization program

[1] Effective March 27, 2007, Care Choices surrendered it certificate of authority and is no longer licensed to conduct business as a health maintenance organization. The assets and obligations of Care Choices were acquired by Priority Health which is now responsible for processing all Care Choices claims and any appeals under the Patient Right to Independent Review Act. These changes do not affect the Commissioner's Final Decision in this external review.

was not covered. He says he was admitted through the emergency room so he should have been notified if there were coverage concerns.

In a letter dated August 14, 2007, the Petitioner's therapist wrote, "he was suicidal, psychotic, very depressed and anxious and needed to be hospitalized for further monitoring because he was not safe at home. He also needed medication adjustment and also close monitoring."

The Petitioner and his wife cannot understand why the Respondent will not provide coverage for care that was recommended and was medically necessary.

Respondent's Argument

In its final adverse determination, the Respondent referred to the following sections of its certificate of coverage to support its decision:

> **6.16 General Limitations and Exclusions**
> The following are not Covered Services:
> * * *
> (1) Services that require prior authorization, but which were not prior authorized. A current list of services that require prior authorization is available by calling HMO's Customer Service department at the number listed in the Member Handbook or on the ID Card.
> * * *
> (11) Educational and recreational therapies
> * * *
> (22) Physical, occupational and speech therapy necessary or designed to treat developmental delays or congenital abnormalities and conditions; to treat chronic conditions; or to maintain current function. This exclusion does not apply when (i) no previous treatment has been received by the Member and the Member's capabilities have recently deteriorated; (ii) or intervening medical complications have affected physical function.

The Respondent's final adverse determination dated September 25, 2007, states:

> Therapy received from XXXXX Hospital from January 2, 2007 thru January 19, 2007 was not prior approved. All covered therapies require prior approval. Maintenance types of therapies of any kind or therapies for chronic conditions are not covered benefits.

Respondent says it "has no record of having received a coverage inquiry or request for prior authorization from the Petitioner or his spouse prior to him receiving the requested

services. . . Had [Petitioner] or his spouse inquired about coverage or had prior approval been requested for mental health services as required by [Petitioner's] HMO contract, [he] would have been informed of the coverage exclusion." (Letter of October 16, 2007 to OFIS.)

Respondent believes it properly denied the Petitioner's request for retroactive authorization.

Commissioner's Review

Prior approval of nonemergency medical care is a common requirement of HMOs. Petitioner's failure to obtain such approval would disqualify the partial hospitalization treatment from coverage, absent a reason that made obtaining such approval impossible. In addition, it is required that treatment be medically necessary in order to be covered.

The question of the medical necessity of continued partial hospitalization through January 19, XXXX was submitted to an IRO. The IRO reviewer is a physician certified in psychiatry and neurology a diplomate in the specialty of psychiatry. This psychiatrist is also a clinical assistant professor in the department of psychiatry at a university-based school of medicine. The reviewer's report includes the following analysis:

> Very little clinical information is available for review. The facility did not submit a copy of a psychiatric evaluation, progress notes, or physician's orders. The only information submitted by the facility was a copy of the invoice which included services such as activity therapy, training and education, and group psychotherapy for a diagnosis of . . . unspecified psychosis. No physician's bills were submitted.
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> * * *
>
> There is no indication from the records submitted for review that the services were rendered in conjunction with an attending physician who was in charge of the case. Additionally, the services appear to be primarily geared towards education and recreation. A review of the data provided indicates that the health plan did cover the group therapy. . . . The information presented in sum does not indicate that the enrollee met the criteria for a medical emergency for the dates of service January 2 through January 19, 2007. The data reviewed indicates that the partial hospital program was part of a follow-up plan from an inpatient treatment. Although clinical data is limited, there is no evidence from the record that the enrollee was suffering from such a condition; therefore, medical necessity for the services has not been established.

> The reviewer concluded that the medical care in question was not medically necessary nor was it treatment of a medical emergency. The reviewer recommended that the denial of coverage be upheld.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner; in a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's analysis is based on extensive experience, expertise, and professional judgment. The Commissioner can discern no reason why that judgment should be rejected in the present case. Therefore, the Commissioner accepts the recommendation of the IRO that the denial of coverage be upheld.

V
ORDER

The final adverse determination of September 25, 2007 is upheld.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

Note: Because of the acquisition of Care Choices' business by Priority Health, any ongoing correspondence or other actions intended for Care Choices should now be directed to Priority Health at the following address:

Priority Health
1231 East Beltline NE
Grand Rapids, MI 49525-4501